

SESSION 2B: Community and Clinical Approaches for Improved Adherence, Retention and Differentiated Care.

ART Adherence Clubs

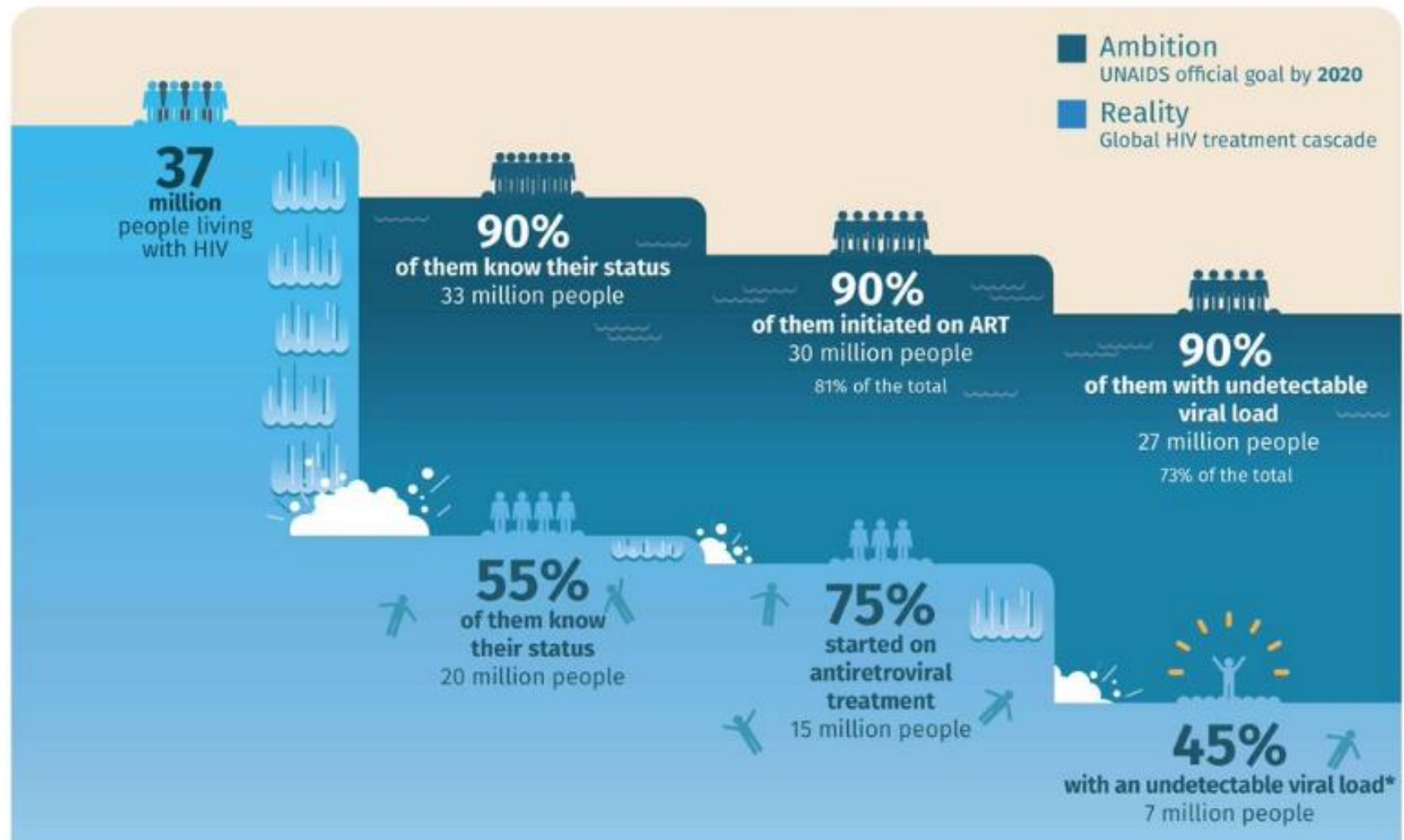
long-term retention in care

Suhair Solomon

Medecins Sans Frontieres

HIV care for epidemic control

Ambitions vs reality

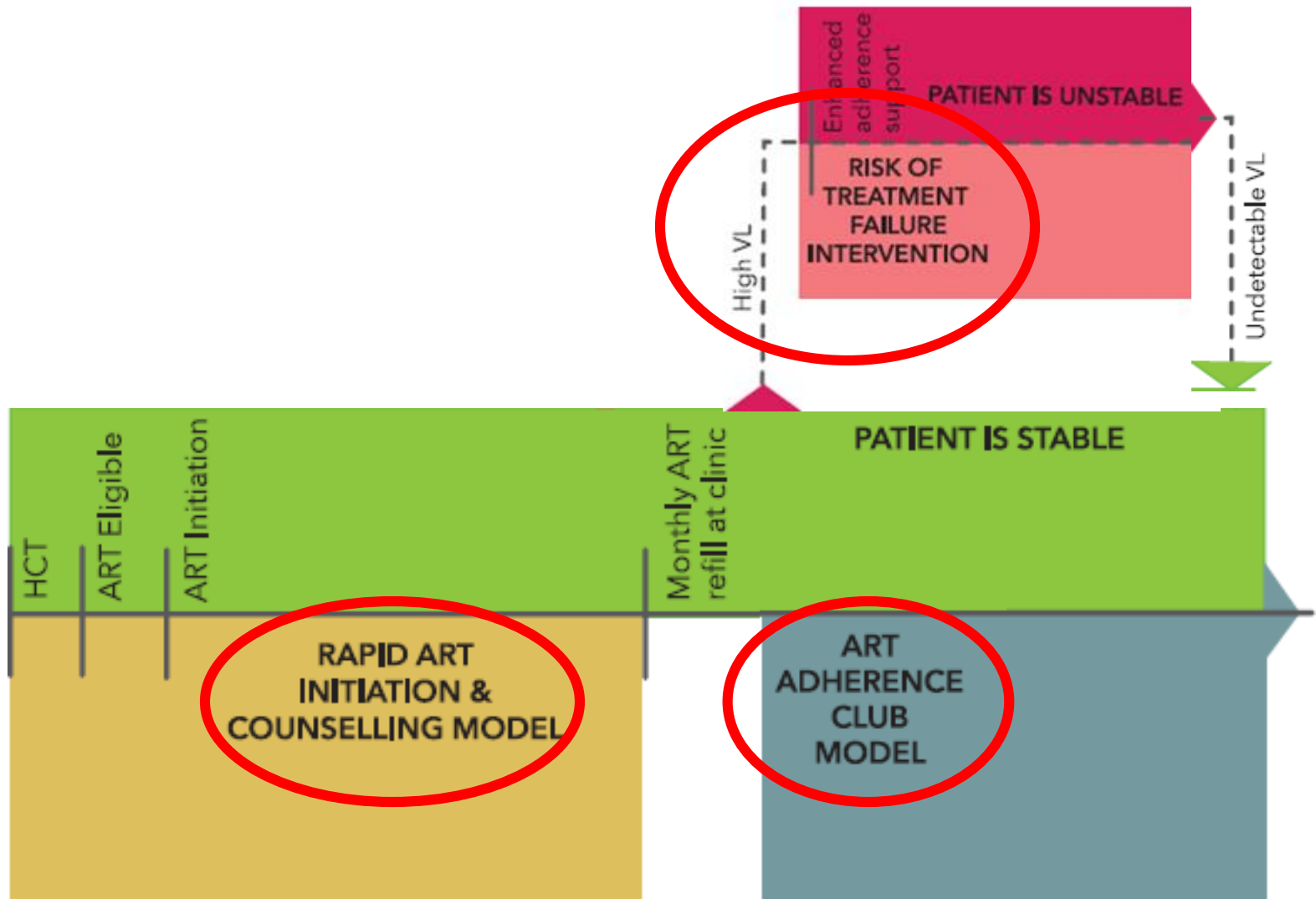


Treatment cascade or treatment cliff? Successful HIV treatment, as measured by an undetectable viral load, is key for epidemic control.
Reaching the 90:90:90 UNAIDS targets will require considerable future commitment and investment.

Source: UNAIDS

*Fox MP; Rosen S. Retention of Adult Patients on Antiretroviral Therapy in Low- and Middle-Income Countries: Systematic Review and Meta-analysis 2008-2013

Differentiated Models of Care



Model Variation in Cape Metro

Area of adaptation	Types of adaptation
Eligibility criteria	<ul style="list-style-type: none"> • Duration of time of ART • Regimens • Number of suppressed viral loads • Co-morbidities
Patient population	<ul style="list-style-type: none"> • General adult population • Families • Youth • Men • High Risk (experienced viral rebound in the past)
Location of Clubs	<ul style="list-style-type: none"> • Within ART facility • Community venue close to facility • Community venue close to club member's home • Home of Club member
Cadre of staff facilitating the Club	<ul style="list-style-type: none"> • Lay counsellor • Community health worker • Nurse (professional or auxillary) • Pharmacy assistant • Club member
ART dispensing strategy	<ul style="list-style-type: none"> • Pre-packed at central dispensing unit • Pre-packed at health facility
Integrated services provided	<ul style="list-style-type: none"> • Condom distribution • Family planning • TB/hypertension/diabetic drug supply



Changes to minimum club eligibility criteria

	2011	2012	2015
Duration on ART	18 months	12 months	6 months
No. of suppressed viral loads	2	2	1
CD4 threshold	>200 cells/ml	None	None
Regimen	1 st line	1 st and 2 nd line	1 st and 2 nd line
Co-morbidities	No co-morbidities	No co-morbidities	No current TB Stable co-morbidities
Age	>18 years	>18 years	Family and youth focused clubs allowed

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Model variation: Community venue close to facility

Grimsrud A et al. *Journal of the International AIDS Society* 2015, **18**:19984

<http://www.jiasociety.org/index.php/jias/article/view/19984> | <http://dx.doi.org/10.7448/IAS.18.1.19984>



Research article

Implementation of community-based adherence clubs for stable antiretroviral therapy patients in Cape Town, South Africa

Anna Grimsrud^{S,1}, Joseph Sharp², Cathy Kalombo³, Linda-Gail Bekker^{2,4} and Landon Myer¹

IMPLEMENTATION AND OPERATIONAL RESEARCH: EPIDEMIOLOGY AND PREVENTION

Community-Based Adherence Clubs for the Management of Stable Antiretroviral Therapy Patients in Cape Town, South Africa: A Cohort Study

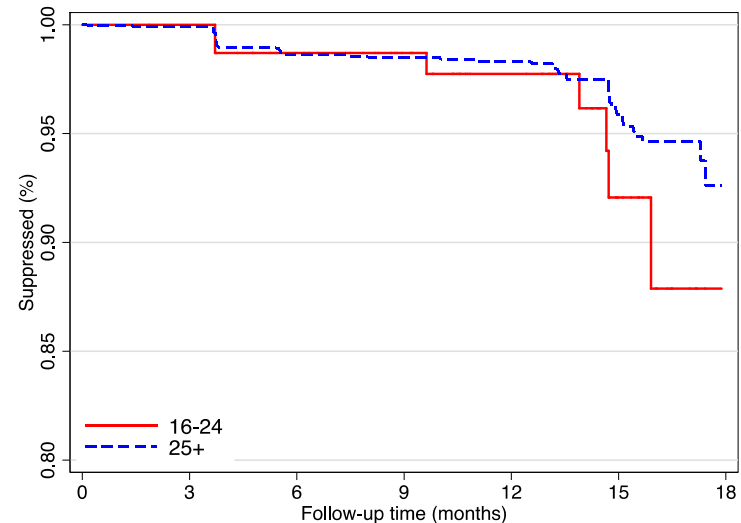
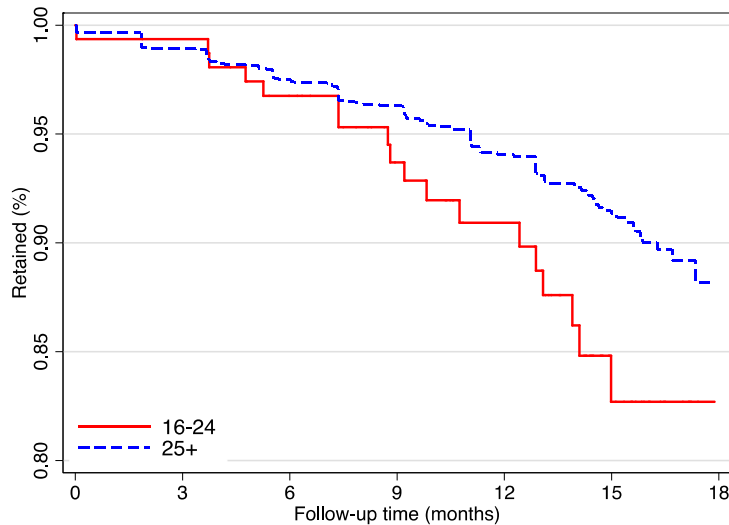
Anna Grimsrud, MPH, PhD, Maia Lesosky, PhD,*† Cathy Kalombo, MBChB,‡
Linda-Gail Bekker, PhD,†§ and Landon Myer, PhD**



Model variation: Community venue close to FACILITY

Results – Among Club patients

- Retention – **94%** at 12-months
- VL suppression – **98%** at 12-months



- **No difference by gender or in those who sent a “buddy”**
- **Increased risk in patients 16-24 years at ART initiation – reinforcing the need for adapting club to this group**

Model variation: Community venue close to PATIENT

Community based ART adherence Clubs:
A community model of care for ART delivery



Suhair Solomon, Phumelele Trasada, Gabriela Patten,
Fanelwa Gwashu, Lillian Twentey, Lynne Wilkinson

Retained in ART care
100 (99%)

Retained in Club care
95 (94%)



- **Good referral mechanism into club care and back to facility care**

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Model variation: longer dispensing interval

less visits, and support adherence in circular migration

4m vs. 2m ART supply in clubs: equivalent outcomes

TABLE 1. Comparing Outcomes of Adherence Club Members Receiving 4 Months vs. 2 Months of ART

	No. ACs	Defaulting				Risk Ratio (95% CI)	P
		Total	In Care	Defaulted	Defaulted, %		
Overall							
Group A: 4 mo	42	1054	1013	41	3.89	0.95 (0.61–1.49)	0.823
Group B: 2 mo	34	806	773	33	4.09		
Total	76	1860	1786	74	3.98		
		Viral Load				Risk Ratio (95% CI)	P
		Total	<400	>400	Not Suppressed, %		
Overall							
Group A: 4 mo		842	811	31	3.68	1.06 (0.63–1.81)	0.817
Group B: 2 mo		665	642	23	3.46		
Total		1507	1453	54	3.58		

Grimsrud, A., Patten, G., Sharp, J., Myer, L., Wilkinson, L., & Bekker, L. G. (2014). Extending dispensing intervals for stable patients on ART. *JAIDS Journal of Acquired Immune Deficiency Syndromes*, 66(2), e58-e60.

Lessons from Scale Up

- Different models for different patient populations, patients should be able to choose
- Steering Committee for strategic decision making is necessary
- Setting appropriate targets (50-60% of RIC)
- Efficiencies for annual scheduling, annual 12m scripting cycle and effective alternative pharmacy dispensing
- Longer treatment supply intervals
- Quality of care cannot be compromised (deliver on the promise), maintain essential clinical requirements
- Evaluate the role of partner champions, with an eye on sustainability – not dependency
- Counselors/CHWs are valued ***critical resource*** to realize our targets



Acknowledgements

- **Lynne Wilkinson** for contributions to this presentation
- City of Cape Town and Western Cape Provincial **HAST teams** and **Club Steering Committee**
- Primary healthcare clinics **colleagues** that have supported pilots
- **HIV positive patients** in the Cape Metro for their continued support and insight in finding ways to improve the service provided to them



SESSION 2B: Community and Clinical Approaches for Improved Adherence, Retention and Differentiated Care. Adherence Clubs,
Suhair Solomon, MSF/Doctors Without Borders

- Transition stable patients into simplified models for ART delivery that better suit ***their*** needs – clubs & quick drug pick-up options - in order to effectively utilize valuable clinician time to provide enhanced adherence & clinical care for complex and unstable patients.
- Efficiencies such as 12m scripting cycle for stable patients, longer dispensing of treatment, alternative dispensing avenues, are critical
- ***Lay healthcare workers (counselors/CHWs)*** drive this program facilitating clubs in facility and community. Provision for their role must be clearly defined and supported.